PRINTED: 06/14/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		475044	D WING				С
		17E641	B. WING			06	/12/2013
	OVIDER OR SUPPLIER ERRACE NURSING & RE	HABILITATION CENTER		201	ET ADDRESS, CITY, STATE, ZIP CODE I E FLAMING RD .ATHE, KS 66061		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		OULD BE COMPLETIC	
F 000	INITIAL COMMENTS	3	F	000			
	Non-compliance Rev	ns represent the findings of a isit and Complaint i20, #KS65512, #KS66305					
F 248 SS=E	483.15(f)(1) ACTIVIT INTERESTS/NEEDS		F	248			
	of activities designed the comprehensive a	ride for an ongoing program to meet, in accordance with ssessment, the interests and and psychosocial well-being					
	by: The facility identified The sample included observation, record re facility failed to provide	1, #4006, #4007, #4008) of					
	Findings included:						
	5/30/13 listed the followard following from the fol	er Sheet (POS) dated owing diagnoses for resident reme emotional disturbance) essive mental disorder ng memory, confusion).					
	Assessment Reference noted the resident ha memory problems an with decision-making	num Data Set 3.0 with the ce Date (ARD) 5/10/13 d short and long term d was moderately impaired skills. It was important for usic, do things in groups of					
LABORATORY	I DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE ING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E641	B. WING				C 12/2013	
	OVIDER OR SUPPLIER	HABILITATION CENTER	•	20	EET ADDRESS, CITY, STATE, ZIP CODE 11 E FLAMING RD LATHE, KS 66061	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 248	and was somewhat in participate in religious activities, keep up with pets or animals. The supervision to being it Activities of Daily Livitiextensive assistance. The Care Area Assess dated 5/14/13 noted it that he/she was in a report the season or responding to questic things irrelevant to the The ADL CAA dated was admitted from an mostly independent whout required some occassistance. Care plan dated 5/21 listed interventions to relaxed manner, special introduce self frequents in the clinical record lace activities. Activity Interest Asset the resident was alert long term memory preserved.	men the weather was nice important for him/her to sevents, do favorite the the news, and be around resident required staff independent with all ing (ADL) except needed with personal hygiene. Sesment (CAA) for Cognition the resident was not sure nursing home, was unable to the year, and had difficulty ons as he/she spoke of equestions asked by staff. 5/14/13 listed the resident nother facility. He/she was with mobility and transfers, casional physical //13 for impaired cognition maintain a calm and ak slowly and distinctly, intly, provide visual cues, use a reorientation/validation as sistency in the daily routine, an speaking and encourage room.	F	248				

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F 248	were noted as past in well with spouse. Sta activities and assist a The Activity Progress (untimed) said the rest to name, and enjoyed watching TV. Review of the Activity May 2013 listed the relistened to music several active participant of some other facility off. Observation on 6/4/13 resident laid in bed, who was a considered to music several active participant of some other facility off. Observation on 6/4/13 resident laid in bed, who was a considered to music several active participant of some other facility off. Observation on 6/4/13 resident laid in bed, who was a considered to music several activity and them said he/she enjoyed to be servation on 6/5/13 resident attended the Cobservation revealed Bingo activity on 6/5/13 resident remained in large activity on 6/5/13 resident remain	ning TV. News and religion terests. He/she interacted off to encourage group is the resident was able. note dated 5/20/13 sident was alert and oriented it listening to music and it listening to music and it Participation Record for esident watched TV and eral days a month and was it to 3 days in the month in tered activities. 3 at 11:50 A.M. revealed the vatching TV. M. there was a crossword eralying on the bedside aid he/she did not read the in all the rooms. He/she doing crossword puzzles. 3 at 10:30 A.M. revealed the religious events activity. The residents attended the in all 3 at 3:00 P.M. but this his/her room, door closed,	F	248			

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	OVIDER OR SUPPLIER	HABILITATION CENTER	1	201	ET ADDRESS, CITY, STATE, ZIP CODE E FLAMING RD ATHE, KS 66061	, 50	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ON SHOULD BE HE APPROPRIATE	
F 248	HH said the facility w plans on everyone ar MDS triggered. He/s make the care plans residents' likes and d An interview on 6/5/1 care staff Q said the consisted of going to and visiting with his/hotherwise the resider watched TV or napper linterview on 6/5/13 a administrative staff C admitted a resident, horeign and Administrative staff C activity program and Administrative staff C activity assessment proceeding the resident on the second activity assessment proceeding the resident of each resident. He the Activity Interest A residents likes and diacknowledged there for this resident. An interview on 6/5/1 administrative nursing should have an indivinctivities. An interview on 6/5/1 care staff R said the like with his/her spouse in	ould start doing activity care and not just those that the he said the facility would individualized to reflect islikes. 3 at 1:45 P.M. with direct resident on the day shift Bingo or going to the unit er spouse. He/she said at stayed in his/her room and ed. 1 2:40 P.M. an interview with said when the facility first ne/she visited with the new and day and explained the the activity calendar. It said he/she completed the cortion of the MDS by the de a progress note at and then did the care plan el/she said he/she did not use ssessment to figure out the slikes. He/she was not an activity care plan	F	248			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CC	(X3) DATE SURVEY COMPLETED		
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	OVIDER OR SUPPLIER	HABILITATION CENTER		201 E	T ADDRESS, CITY, STATE, ZIP CODE E FLAMING RD ITHE, KS 66061	1 00/	12/2013
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F 248	Activities with revisio residents had the right activities of their choi Therapeutic Recreati maintain a daily reco involvement. The facility failed to pindividualized activity	policy for Participation in n date of 9/1/11 said nt to attend and participate in ce. The Director of onal Services would rd of resident activity	F	248			
	4/29/13 listed the foll-#4006: dementia (pr characterized by failing depression (abnormatic characterized by exasadness, worthless of hallucinations (sensing appear to be real, but by the mind). The annual Minimum Assessment Referent listed the resident hamemory problems and with decision making listening to music and He/she needed extermobility, transfers, dr	ggerated feelings of ess and emptiness), and any things while awake that trinstead have been created Data Set (MDS) 3.0 with the ce Date (ARD) of 3/15/13 d short and long term and was severely impaired skills. The resident liked d doing things in groups. Insive assistance with bed essing, eating, personal assistance with walking on					

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F 248	3/18/13 noted the rebecause he/she did attended activities because he/she did attended activities be observer. The care plan for acresident needed ver Interventions include activities on and off. The Activity Interest noted the resident watern memory loss, was music, exercise, pet encouragement to a sitting in the day roconcept of the month of the participating in musice some exercise. He/activities such as was people around him/has Review of the month Record dated Februa 2013, May 2013 and resident was an activities, watching exercise and current resident was a pass and watching TV. In the resident was an activities, pet visits a constraint of the resident was an activities, pet visits and activities, pet visits and activities.	rea Assessment (CAA) dated esident triggered the CAA little in activities. He/she ut was mostly a passive stivities dated 6/2/13 noted the ebal cueing to participate. Bed the resident to attend the unit. Assessment dated 3/15/13 was alert with short and long was non-verbal, liked games, as and TV. He/she needed attend activities and enjoyed om, watching TV. Trogress notes dated 3/15/13 goyed sitting in the dayroom of therapy, pet visits, and she enjoyed independent atching TV and observing her. The Activity Participation hary 2013, March 2013, April of June 2013 revealed the ve participant almost daily go TV, sensory stimulation, the events. In May 2013 the ive participant with music in June 2013 staff recorded active participant in 1 to 1	F	248			

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 248	his/her head down ar on but muted while a blue grass music. An observation on 6/4 the staff assisted the room, and laid him/he P.M. volunteers and for pet therapy, the reduring this time. An observation on 6/9 the resident sat on the had his/her head down.	buch in the day room with ad eyes open. The TV was compact disc (CD) played 4/13 at 2:10 P.M. revealed resident to his/her her er down for a nap. At 2:35 dogs came in the dayroom esident remained in bed 5/13 at 10:15 A.M. revealed e couch in the dayroom, /n, eyes closed and rested he day room, TV on and	F	248			
	care staff S said the ractivities sometimes seemed to enjoy must An interview on 6/5/1 care staff T said the racticipated in ball to said the resident like reading to him/her and Staff said the TV was going so the resident auditory stimulation. must be later in the disaw pets on the unit said the resident laid nap.	out usually watched. He/she sic and ball toss. 3 at 1:55 P.M. with direct esident occasionally as but not too often. He/she did music but did not like staff did not like to watch TV. on mute and the music					

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F 248	resident would occar 1 to 1 or would some activities with staff a An interview on 6/5/nursing staff J said of were responsible for residents. He/she so daily on the unit dep activity calendar. W resident was an activate individual partivate we did not use the A the resident's activity residents' daily activate On 6/5/13 at 2:40 P.I adminstrative staff C admitted a resident, resident on the seco activity program and said he/she complet portion of the MDS to a progress note regal did the care plan for he/she did not use the Assessment to figure dislikes. He/she said secured unit did all t residing on the unit. expected the staff or refer to the care plan program from the car An interview on 6/5/n administrative nursin	here was one game the sionally play with him/her on a stimes participate in group sistance. 13 at 2:15 P.M. with licensed on the secured unit the staff doing activities with the aid what activities they did ended on what was on the ethen mark whether the ve or passive participant on cipation record. He/she said activity Intake Assessment or very care plan for planning the staid when the facility first he/she visited with the new and day and explained the the activity calendar. He/she ed the activity assessment by the fifth day and then made arding the resident and then each resident. He/she said the Activity Interest e out the residents' likes and do the staff who work on the he activities for the residents. He/she said he/she anyone doing activities to an and gauge the activity re plan.	F	248				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E641	B. WING				C / 12/2013
	NAME OF PROVIDER OR SUPPLIER ROYAL TERRACE NURSING & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			201 E	T ADDRESS, CITY, STATE, ZIP CODE E FLAMING RD ATHE, KS 66061	1 00	12/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	activities. He/she ac used only the monthl not an initialized activities dent. The facility provided Activities with revision residents had the right activities of their choise Therapeutic Recreati maintain a daily reconsultation involvement. The facility failed to prindividualized activity	cknowledged that when staff y activity calendar, there was vity program for each policy for Participation in n date of 9/1/11 said nt to attend and participate in ce. The Director of onal Services would rd of resident activity	F	248			
	the following diagnost psychosis (any major gross impairment in redementia (a progress characterized by failing delusional disorder (a perception held by a shows it is untrue), a (abnormal emotional exaggerated feelings emptiness and hopel the Annual Minimum the Assessment References in page 1.5 mg/s.	sive mental disorder ng memory, confusion), an untrue persistent belief or person although evidence nd depressive disorder state characterized by of sadness, worthlessness,					

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F 248	term memory problen impaired with decision the resident liked to lipets or animals, doing participate in favorite events. He/she need with all Activities of D. The Care Area Assesdid not trigger. The care plan dated listed for staff to engaresident regarding sp. University (KU). The care plan for action of the resident resident to attend. The Activity Interest A listed the resident was him/her "Coach", enjochurch on TV. The resterapy, games, musical Activity Progress note noted the resident sproom, was present for passive participate as able. Review of Weekly Chemostric participate as able.	ns and was moderately n-making skills. Staff noted sten to music, being around g things in groups, activities and in religious ed extensive assistance aily Living (ADL). Issment (CAA) for activities 3/1/13 for impaired cognition age in conversation with the orts, preferring Kansas vities with revision date of dent needed verbal cueing to activities on the unit. Assessment dated 2/17/13 as alert, liked staff to call byed sports and watched esident participated in pet ic, and TV. as dated 5/13/13 (untimed) ent a lot of time in the day or activities and was a remost. The activity staff to attend group activities and marting dated 3/3/13 noted as included visiting with staff	F	248			

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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		201	ET ADDRESS, CITY, STATE, ZIP CODE I E FLAMING RD ATHE, KS 66061	1 00/	12/2010
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F 248	the resident participal 1 on 1 with special carvolunteers. Review of the month Record for February 2013, May 2013, and resident an active participant in February, March, a passive participant in Stimulation in May 20 resident was an active entertainment, 1 to 1 An observation on 6/staff visited with the staff assisted the room, and laid him/h. P.M. volunteers and for pet therapy, the reduring this time. An observation on 6/the resident sat with dining room. The resparticipate in activitie muted, and music pla (CD). An interview on 6/4/	narting dated 5/12/13 noted ated in group activities and are staff and hospice By Activity Participation 2013, March 2013, April of June 2013 revealed the articipant in all events, music, current aulation, and TV nearly daily and April. He/she was a music, TV, and sensory 2013. In June 2013 the are participant for and watching TV. 4/13 at 12:45 P.M. hospice resident at the dining room actively engaged in	F	248			

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F 248	bread machine sever aroma therapy for the An interview on 6/4/1 care staff S said the redo ball toss, watch The said the resident was today but sometimes they came and the resident was today but sometimes they came and the resident was today but sometimes they came and the resident of the TV care staff T said the resident of the TV or said they had the TV compact disc (CD) plauditory stimulation. An interview on 6/5/1 care staff T said on the were responsible for residents. He/she said on the unit depended calendar. We then make an active or passindividual participation did not use the Activit resident's activity car residents' daily activit Interview on 6/5/13 and administrative staff Cadmitted a resident, it resident on the secondactivity program and said he/she complete portion of the MDS by	al times a week. It was their a residents. 3 at 3:35 P.M. with direct resident liked to talk sports, and visit with staff. He/she in bed when the dogs came he/she was awake when sident enjoyed the dogs. 3 at 1:55 P.M. with direct resident did not participate in did the resident did not pay even to the music. He/she on and muted with the aying music for visual and 3 at 2:15 P.M. with direct resecured unit the staff doing activities with the id the activities they did daily on what was on the activity tark whether the resident sive participant on their in record. He/she said we see plan for planning the ites.	F	248				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 248	did the care plan for the/she did not use the Assessment to figure dislikes. He/she said secured unit do all thresiding on the unit. expected the staff or refer to the care plan program from the care. An interview on 6/5/1 administrative nursing should have an individuativities. He/she accould the monthly activities and initialized activity. The facility provided Activities with revision residents had the right activities of their choin Therapeutic Recreati maintain a daily recommon the facility failed to prindividualized activity his/her interests for the resident.	each resident. He/she said e Activity Interest out the residents' likes and I the staff who work on the e activities for the residents He/she said he/she anyone doing activities to and gauge the activity e plan. 3 at 2:50 P.M. with g staff D said each resident dualized care plan for eknowledged when staff used vity calendar, there was not program for each resident. policy for Participation in n date of 9/1/11 said nt to attend and participate in ce. The Director of onal Services would rd of resident activity provide an ongoing r program in accordance to his cognitively impaired	F	248			
	4/30/13 listed the followard 4/30/8: Alzheimers (er Sheet (POS) dated owing diagnoses for resident progressive mental erized by confusion and					

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		IDENTIFICATION NUMBER:		TIPLE CO	(X3) DATE SURVEY COMPLETED		
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F 248	memory failure) and r The Annual Minimum the Assessment Refe listed it was very imported favorite activities, par do things with groups and be around pets on The quarterly Minimu Assessment Reference listed the resident had memory problems an cognition. The reside assistance with bed in hygiene, toilet use, and The Care Area Assest dated 1/16/13 noted to only. He/she was undured supervise The CAA for activities The CAA for activities The CAA for behavior resident enjoyed sittir watching TV, listening with other residents. The care plan dated of resident needed verb	Data Set (MDS) 3.0 with rence Date (ARD) of 1/2/13 ortant for the resident to do ticipate in religious events, of people, listen to music, ranimals. Im Data Set (MDS) 3.0 with the Date (ARD) of 3/20/13 dishort and long term dishort and long term dishort and long term disholity, transfers, personal and dressing. Issement (CAA) for cognition the resident was alert to self able to make self tood what others said to that memory impairments sion with decision making. Is did not trigger. It dated 1/16/13 noted the region the common area of to the radio, and visiting ones listed for the resident to	F	248			

Facility ID: N046023C

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F 248	the resident wandere and from rooms on th items and carried the resident attended and	note dated 5/29/13 revealed d with occasional pacing to e unit. He/she picked up m with him/her. The	F	248			
	noted the resident wa	Assessment dated 3/15/13 as alert, enjoyed games, The resident's spouse cipated in the family					
	said the resident enjouse. He/she liked	e dated 3/15/13 (untimed) yed visits from his/her to carry a doll, walked all icipated in activities such as nd pet visits.					
	Record dated Februa 2013, May 2013 and resident was an activevents, exercise, mus sensory activities alm resident was a passiv	ost daily. In May 2013, the re participant in music and 2013 revealed he/she was					
	the resident sat in the doll, talking to it and s	A/13 at 12:55 P.M. revealed day room with the baby showing it different items terpieces. Music played in was on, and muted.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	A. BUILDING			С			
		17E641	B. WING			06/	/12/2013
	OVIDER OR SUPPLIER ERRACE NURSING & RE	HABILITATION CENTER		201	ET ADDRESS, CITY, STATE, ZIP CODE E FLAMING RD ATHE, KS 66061		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 248	Continued From page	e 15	F	248			
	holding the doll and v playing ball toss in th and 3 volunteers carr	nt on 6/4/13 at 2:31 P.M. vatched other residents e day room. 3 large dogs ne onto the unit. The t did not attempt to pet or					
	The resident on 6/4/1 table in the day room residents color.	3 at 2:47 P.M. sat at the and watched other					
	the resident sat in the other residents and ta	5/13 at 10:10 A.M. revealed e day/dining room, watched alked to no one particular. d while music continued to					
	care staff S said the r	3 at 3:40 P.M. with direct resident loved the baby doll, yed the pets but usually just					
	care staff T said the r walked all over the ur other residents. He/s listened when I read said the resident did music or to the TV.	3 at 1:55 P.M. with direct resident loved the doll, nit, and talked to staff and she said at times the resident to the residents. He/she not pay much attention to He/she said they have the TV e compact disc (CD) playing auditory stimulation.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE C	` '	(X3) DATE SURVEY COMPLETED		
		17E641	B. WING			l	C 12/2013	
	OVIDER OR SUPPLIER	HABILITATION CENTER	•	201	ET ADDRESS, CITY, STATE, ZIP CODE E FLAMING RD ATHE, KS 66061	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 248	nursing staff J said the doll baby, occasional activities with a certain clapped along with the An interview on 6/5/1 nursing staff J said of were responsible for residents. He/she said aily on the unit, depractivity calendar. We resident was an activity calendar. We resident was an activity resident's activity resident's activity residents' daily activity residents' daily activity residents' daily activity residents and said he/she completed portion of the MDS by a progress note regardid the care plan for the/she did not use the Assessment to figure dislikes. He/she said secured unit do all the residing on the unit. expected the staff or refer to the care plan program from the care. An interview on 6/5/1	3 at 2:05 P.M. with licensed be resident liked to carry a by enjoyed doing 1 on 1 in board game, and at times e music. 3 at 2:15 P.M. with licensed in the secured unit the staff doing activities with the lid what activities they didended on what was on the eithen mark whether the e or passive participant on pation record. He/she said ctivity Intake Assessment or care plan for planning the lies. 1 2:40 P.M. with said when the facility first he/she visited with the new and day and explained the the activity calendar. He/she and the activity assessment or the fifth day and then made reding the resident and then each resident. He/she said the staff who work on the eactivities for the residents He/she said he/she anyone doing activities to and gauge the activity e plan.	F	248				

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN			ONSTRUCTION	COME	(X3) DATE SURVEY COMPLETED	
		17E641	B. WING			06/12/2013		
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	'	201	ET ADDRESS, CITY, STATE, ZIP CODE E FLAMING RD ATHE, KS 66061	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 248 F 279 SS=E	activities. He/she a only the monthly act an initialized activity The facility provided Activities with revision residents had the rigactivities of their choral the residents and ally recommend in the facility failed to individualized activithis/her interests for resident. 483.20(d), 483.20(k), COMPREHENSIVE A facility must use the	ridualized care plan for oknowledged when staff used ivity calendar, there was not program for each resident. policy for Participation in on date of 9/1/11 said that to attend and participate in ice. The Director of cional Services would ord of resident activity provide an ongoing of program in accordance to this cognitively impaired (1) DEVELOP CARE PLANS we results of the assessment		248				
	The facility must dev plan for each resider objectives and timet medical, nursing, an needs that are ident assessment. The care plan must to be furnished to at highest practicable ppsychosocial well-be §483.25; and any sebe required under §483.25	relop a comprehensive care not that includes measurable ables to meet a resident's d mental and psychosocial fied in the comprehensive describe the services that are tain or maintain the resident's ohysical, mental, and eing as required under cryices that would otherwise 483.25 but are not provided exercise of rights under						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED	
		17E641	B. WING			C 12/2013
	OVIDER OR SUPPLIER	HABILITATION CENTER	•	20	EET ADDRESS, CITY, STATE, ZIP CODE 11 E FLAMING RD LATHE, KS 66061	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F 279	under §483.10(b)(4). This REQUIREMENT by: The facility identified The sample included observation, record refacility failed to develorate for activities for 4#4008) of the 4 reside. Findings included: The Physician Ord 5/30/13 listed the follow #4001: agitation (extra and dementia (progress).	e 18 e right to refuse treatment is not met as evidenced a census of 49 residents. 9 residents. Based on eview and interview the op an individualized plan of 4 (#4001, #4006, #4007, ents reviewed for activities. er Sheet (POS) dated owing diagnoses for resident reme emotional disturbance) essive mental disorder ng memory, confusion).	F	279	DEFICIENCY	
	Assessment Reference noted the resident had memory problems and with decision-making him/her to listen to make people, go outside whand was somewhat it participate in religious activities, keep up with pets or animals. The supervision to being it Activities of Daily Livit extensive assistance	d was moderately impaired skills. It was important for usic, do things in groups of then the weather was nice mportant for him/her to sevents, do favorite the news, and be around resident required staff				

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F 279	that he/she was in a report the season or tresponding to question things irrelevant to the The ADL CAA dated was admitted from an mostly independent whous the property of the provide consistence. Care plan dated 5/21 listed interventions to relaxed manner, special introduce self frequents introduce self frequents imple direct request, needed, provide constace the resident when use of visual cues in the clinical record lact activities. Activity Interest Asset the resident was alert long term memory programes, music, exercing gardening, and watch were noted as past in well with spouse. State activities and assist a consideration on 6/4/13 resident laid in bed, were noted that it is the provide consideration on 6/4/13 resident laid in bed, were noted as past in well with spouse. State activities and assist a consideration on 6/4/13 resident laid in bed, were noted as past in well with spouse. State activities and assist a consideration on 6/4/13 resident laid in bed, were noted as past in well with spouse. State activities and assist a consideration on 6/4/13 at 7:50 A.M.	the resident was not sure nursing home, was unable to he year, and had difficulty ins as he/she spoke of equestions asked by staff. 5/14/13 listed the resident other facility. He/she was with mobility and transfers, casional physical 7/13 for impaired cognition maintain a calm and ask slowly and distinctly, titly, provide visual cues, use reorientation/validation as istency in the daily routine, in speaking and encourage froom. 6/2 cked a care plan for 6/3 sment dated 5/13/13 listed to name and had short and oblems. He/she enjoyed se, reading, food, pets , ning TV. News and religion terests. He/she interacted off to encourage group is the resident was able.	F	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		17E641 B. WING				C 1 2/2013	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	l	201 I	T ADDRESS, CITY, STATE, ZIP CODE E FLAMING RD ATHE, KS 66061	1 00,	12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279	Bible, they had them said he enjoyed doir Observation on 6/5/resident attended the Observation reveale Bingo activity on 6/5 resident remained in room dark, TV on, ewith the resident at 3 enjoyed Bingo but he anyone asking him/h. An interview on 6/5/HH said the facility with plans on everyone a MDS triggered. He/s make the care plans residents likes and consisted of going to and visiting with his/otherwise the reside watched TV or nappolitical likes and consisted of going to and visiting with his/otherwise the reside watched TV or nappolitical likes and consisted of going to and visiting with his/otherwise the reside watched TV or nappolitical likes and consisted of going to and visiting with his/otherwise the reside watched TV or nappolitical likes are sident, resident on the seconactivity program and said he/she complet portion of the MDS is	said he/she did not read the in all the rooms. He/she in all the rooms activity. If a the room in a the room in a the religious events activity. If a the room in all the room in a the room	F	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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	OVIDER OR SUPPLIER	HABILITATION CENTER		20	EET ADDRESS, CITY, STATE, ZIP CODE D1 E FLAMING RD LATHE, KS 66061		
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F 279	Activity Interest Asser residents likes and di acknowledged there of for this resident. An interview on 6/5/1 administrative nursing should have an indiviactivities. An interview on 6/5/1 care staff R said the rewith his/her spouse in stayed in his/her roomevening. The facility provided prevision date of 9/1/1 plan of care will be esand updated in accorregulatory requirement basis". The procedur additional problem and MDS, which will need plan. All direct care sunderstand and follow Plan". The facility failed to dactivity care plan for the said of the residence of the said of the plan of the said of the procedure of the said of th	said he/she did not use the sement to figure out the slikes. He/she was not an activity care plan 3 at 2:50 P.M. with g staff D said each resident dualized care plan for 3 at 4:45 P.M. with direct resident occasionally visited at the afternoon but usually and watched TV in the colicy for Care Plan with a said an "interdisciplinary stablished for every resident dance with state and federal and the stated "there may be reas not triggered by the to be addressed in the Care staff must always know, witheir Resident's Care evelop and individualized his cognitively impaired vidualized activity program in	F	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E641	B. WING			1	C 12/2013
	OVIDER OR SUPPLIER	HABILITATION CENTER		20	EET ADDRESS, CITY, STATE, ZIP CODE 01 E FLAMING RD DLATHE, KS 66061		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	4/29/13 listed the follo #4006: dementia (pro characterized by failin depression (abnorma characterized by exact sadness, worthlessnethallucinations (sensin appear to be real, but by the mind). The annual Minimum Assessment Reference listed the resident has memory problems and with decision making listening to music and He/she needed extendility, transfers, drowing had been and limited at the unit and in the control of the care plan for acti resident needed verbores.	er Sheet (POS) dated owing diagnoses for resident ogressive mental disordering memory, confusion), I emotional state ggerated feelings of ess and emptiness), and ig things while awake that instead have been created. Data Set (MDS) 3.0 with the ce Date (ARD) of 3/15/13 dishort and long term dispersional was severely impaired skills. The resident liked I doing things in groups. Sive assistance with bed essing, eating, personal assistance with walking on	F	279	DEFICIENCY)		
	noted the resident waterm memory loss, wa	Assessment dated 3/15/13 as alert with short and long as non-verbal, liked games, and TV. He/she needed					

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	OVIDER OR SUPPLIER	EHABILITATION CENTER	•	201	T ADDRESS, CITY, STATE, ZIP CODE E FLAMING RD ATHE, KS 66061			
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F 279	sitting in the day roo Review of Activity Pr said the resident enj participating in music some exercise. He/s activities such as wa people around him/h Observation on 6/4/ resident sat on the c his/her head down a on but muted while a blue grass music. An observation on 6/ the staff assisted the room, and laid him/h P.M. volunteers and for pet therapy, the r during this time. An observation on 6/ the resident sat on th had his/her head do quietly. Music on in muted. An interview on 6/4/ care staff S said the activities sometimes seemed to enjoy mu An interview on 6/5/ with consultant HH s doing activity care pl	ttend activities and enjoyed m, watching TV. rogress notes dated 3/15/13 oyed sitting in the dayroom c therapy, pet visits, and she enjoyed independent atching TV and observing iter. 13 at 12:35 P.M. revealed the ouch in the day room with nd eyes open. The TV was a compact disc (CD) played 14/13 at 2:10 P.M. revealed e resident to his/her her er down for a nap. At 2:35 3 dogs came in the dayroom esident remained in bed 15/13 at 10:15 A.M. revealed he couch in the dayroom, wn, eyes closed and rested the day room, TV on and 13 at 3:35 P.M. with direct resident would join in but usually watched. He/she	F	279				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		PLETED
		17E641	B. WING		 	1	C 12/2013
	OVIDER OR SUPPLIER	EHABILITATION CENTER		201	ET ADDRESS, CITY, STATE, ZIP CODE E FLAMING RD ATHE, KS 66061		
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F 279	to reflect residents' li An interview on 6/5/1 care staff T said the participated in ball to said the resident like reading to him/her ar Staff said the TV was going so the resident auditory stimulation. must be later in the c saw pets on the unit said the resident laid nap. An interview on 6/5/1 nursing staff J said th resident would occas 1 to 1 or would some activities with staff as An interview on 6/5/1 nursing staff J said of were responsible for residents. He/she sa daily on the unit depo activity calendar. We resident was an activ their individual partic we did not use the A the resident's activity residents' daily activity On 6/5/13 at 2:40 P.I adminstrative staff C admitted a resident,	the care plans individualized kes and dislikes. 3 at 1:55 P.M. with direct resident occasionally pass but not too often. He/she did music but did not like staff and did not like to watch TV. It is on mute and the music its had both visual and he/she said pet therapy lay because he/she never during the day shift. He/she down every afternoon for a stimes participate in group is sistance. 3 at 2:03 P.M. with licensed here was one game the sionally play with him/her on a stimes participate in group is sistance. 3 at 2:15 P.M. with licensed in the secured unit the staff doing activities with the said what activities they did is ended on what was on the enter the reference or passive participant on sipation record. He/she said ctivity Intake Assessment or care plan for planning the ties.	F	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		LETED
		17E641	B. WING				C 12/2013
	OVIDER OR SUPPLIER	HABILITATION CENTER	•	201	ET ADDRESS, CITY, STATE, ZIP CODE E FLAMING RD ATHE, KS 66061	, , ,	
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F 279	said he/she completed portion of the MDS by a progress note regarded the care plan for the/she did not use the Assessment to figure dislikes. He/she said secured unit did all the residing on the unit. expected the staff or refer to the care plan program from the care. An interview on 6/5/1 administrative nursing should have an individual activities. He/she addused only the monthle not an initialized activities and updated in according regulatory requiremed basis. The procedure additional problem and MDS, which will need Plan. All direct care understand and follow Plan. The facility failed to cactivity care plan for the said and to the care understand and follow Plan.	the activity calendar. He/she and the activity assessment by the fifth day and then made roing the resident and then each resident. He/she said to be activity Interest to out the residents likes and the staff who work on the reactivities for the residents. He/she said he/she anyone doing activities to and gauge the activity to and gauge the activity to and gauge the activity to anyone doing activities to anyone doing activities to anyone doing activities to anyone doing activities to anyone doing activity anyone doing activity to anyone doing activity program for each the said an "interdisciplinary stablished for every resident dance with state and federal ants and on an as needed anyone activity anyone doing activity anyone doing activity anyone doing activity activity anyone doing activity activity anyo	F	279			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
		17E641	B. WING _			C 6/12/2013
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		STREET ADDRESS, CITY, STATE, ZIP COD 201 E FLAMING RD OLATHE, KS 66061		0/12/2010		
PREFIX	(EACH DEFICII	ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 279	Continued From p	age 26	F 2	79		
	the following diagrams psychosis (any magnoss impairment dementia (a programaterized by felusional disorder perception held by shows it is untrue) (abnormal emotion exaggerated feeling psychosis is the felusional disorder perception held by shows it is untrue).	noses for resident #4007: ajor mental characterized by a in reality testing), senile ressive mental disorder ailing memory, confusion), or (an untrue persistent belief or a person although evidence and depressive disorder anal state characterized by ags of sadness, worthlessness,				
	the Assessment R 2/18/13 noted the term memory prob impaired with decithe resident liked pets or animals, d participate in favorevents. He/she noted that the second secon	Reference Date (ARD) of resident had short and long blems and was moderately sion-making skills. Staff noted				
	did not trigger. The care plan date listed for staff to e	ed 3/1/13 for impaired cognition ngage in conversation with the sports, preferring Kansas				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	OVIDER OR SUPPLIER	HABILITATION CENTER	1	20	EET ADDRESS, CITY, STATE, ZIP CODE 11 E FLAMING RD LATHE, KS 66061		
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F 279	6/2/13 noted the resident resident to attend. The Activity Interest A listed the resident wa him/her "Coach", enjoy church on TV. The restherapy, games, mus. Activity Progress note noted the resident sproom, was present for passive participant for encourage him/her to participate as able. Review of Weekly Chether resident's activities and hospice voluntees.	vities with revision date of dent needed verbal cueing to so. Interventions included for activities on the unit. Assessment dated 2/17/13 so alert, liked staff to call byed sports and watched esident participated in petic, and TV. Les dated 5/13/13 (untimed) eent a lot of time in the day or activities and was a remost. The activity staff to attend group activities and warring dated 3/3/13 noted is included visiting with staff	F	279	DEFICIENCY)		
	1on 1 with special car volunteers. An observation on 6/4 staff visited with the rable. Resident was a conversation with the An observation on 6/4 the staff assisted the and laid him/her down volunteers and 3 dog	4/13 at 12:45 P.M. hospice esident at the dining room actively engaged in					

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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 279	the resident sat with dining room. The reparticipate in activiting muted, and music p (CD). An interview on 6/4 licensed nursing states bread machine severaroma therapy for the An interview on 6/4/care staff S said the do ball toss, watch said the resident watcame today but some when they came and dogs. An interview on 6/5/H said the facility plans on everyone and MDS triggered. He make the care plans residents' likes and An interview on 6/5/care staff T said the activities. He/she sattention to the TV of said they had the The compact disc (CD) plauditory stimulation	is/5/13 at 10:02 A.M. revealed in the other residents in the esident did not actively es. The TV was on and layed from a compact disc. If J said he/she used the eral times a week. It was their he residents. If at 3:35 P.M. with direct resident liked to talk sports, TV and visit with staff. He/she as in bed when the dogs hetimes he/she was awake did the resident enjoyed the. If at 11:20 A.M. consultant would start doing activity care and not just those that the she said the facility would individualized to reflect dislikes. If at 1:55 P.M. with direct resident did not participate in aid the resident did not pay or even to the music. He/she of on and muted with the olaying music for visual and	F	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	were responsible for residents. He/she sa daily on the unit deperactivity calendar. We resident was an activity their individual particity we did not use the Activity residents' daily activity residents' daily activity residents' daily activity residents activity residents activity residents activity resident on the secondartivity program and said he/she complete portion of the MDS by a progress note regarded the care plan for the/she did not use the Assessment to figure dislikes. He/she said secured unit did all the residing on the unit. I expected the staff or refer to the care plan program from the care. An interview on 6/5/1 administrative nursing should have an individual activities. He/she activities. He/she activities. He/she activities activities activities activities activities activities.	the secured unit the staff doing activities with the id what activities they did nded on what was on the then mark whether the e or passive participant on pation record. He/she said stivity Intake Assessment or care plan for planning the ies. 12:40 P.M. with said when the facility first te/she visited with the new d day and explained the she activity calendar. He/she d the activity assessment or the fifth day and then made ding the resident and then each resident. He/she said the Activity Interest out the residents' likes and the staff who worked on the e activities for the residents' He/she said he/she anyone doing activities to and gauge the activity e plan. 3 at 2:50 P.M. with g staff D said each resident dualized care plan for knowledged that when staff or activity calendar, there was	F	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		17E641	B. WING				C 12/2013
	OVIDER OR SUPPLIER	HABILITATION CENTER	l	20	EET ADDRESS, CITY, STATE, ZIP CODE 11 E FLAMING RD LATHE, KS 66061	, 50.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279	plan of care will be es and updated in accor regulatory requirement basis". The procedur additional problem ar MDS, which will need Plan. All direct care sunderstand and follow Plan". The facility failed to dactivity care plan for the same and updated and same accordance.	1 said an "interdisciplinary stablished for every resident dance with state and federal nts and on an as needed re stated "there may be eas not triggered by the to be addressed in the Care staff must always know, witheir Resident's Care evelop and individualized this cognitively impaired vidualized activity program in	F	279			
	#4008: Alzheimers (production character memory failure) and in the Assessment Reference is the disternity of the favorite activities, part do things with groups and be around pets of the quarterly Minimulassessment Reference is the disternity of the resident has memory problems and cognition. The resident the resident has the factor of	owing diagnoses for resident progressive mental erized by confusion and mood disorder. Data Set (MDS) 3.0 with prence Date (ARD) of 1/2/13 portant for the resident to do ticipate in religious events, of people, listen to music, or animals. In Data Set (MDS) 3.0 with the Date (ARD) of 3/20/13 dishort and long term displacements.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		LETED
		17E641	B. WING			1	C 12/2013
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	•	201	ET ADDRESS, CITY, STATE, ZIP CODE E FLAMING RD ATHE, KS 66061		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	dated 1/16/13 noted only. He/she was ur understood or under him/her. The reside and required supervious The CAA for activities. The CAA for behavior resident enjoyed sitt watching TV, listening with other residents. The care plan dated resident needed vertactivities. Interventia attend activities on a The Weekly Charting the resident wanders and from rooms on titems and carried the resident attended an socialization on the ungames. The Activity Interest noted the resident wand parmeetings. Activity Progress No said the resident enj	ssment (CAA) for cognition the resident was alert to self nable to make self stood what others said to not had memory impairments is ion with decision making. It is did not trigger. It is dated 1/16/13 noted the ring in the common area ring to the radio, and visiting 6/2/13 for activities noted the roal cueing to participate in ons listed for the resident to rind off the unit. It is note dated 5/29/13 revealed red with occasional pacing to the unit. He/she picked up rem with him/her. The	F	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		17E641	B. WING			06/	C 12/2013
	OVIDER OR SUPPLIER	HABILITATION CENTER	1	20	EET ADDRESS, CITY, STATE, ZIP CODE 01 E FLAMING RD DLATHE, KS 66061	, , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	An observation on 6/4 the resident sat in the doll, talking to it and such as the table centhe room and the TV. Observed the resident holding the doll and will playing ball toss in the and 3 volunteers came resident observed but talk to them. The resident on 6/4/1 table in the day room residents color. An observation on 6/5 the resident sat in the other resident and tall was on and muted will was on and muted will care staff S said their played ball, enjoyed to watched them. An interview on 6/5/1: with consultant HH sat doing activity care plat those that the MDS to facility would make the to reflect residents like.	icipated in activities such as and pet visits. A/13 at 12:55 P.M. revealed a day room with the baby showing it different items terpieces. Music played in was on, and muted. At on 6/4/13 at 2:31 P.M. vatched other residents a day room. 3 large dogs are onto the unit. The at did not attempt to pet or A at 2:47 P.M. sAT at the and watched other A day/dining room, watched a day/dining room, watched ked to no one particular. TV hile music continued to play. A at 3:40 P.M. with direct assident loved the baby doll, the pets but usually just A at 11:20 A.M. interview and the facility would start ans on everyone and not just iggered. He/she said the e care plans individualized	F	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		17E641	B. WING			1	C 12/2013
	OVIDER OR SUPPLIER	HABILITATION CENTER	•	201	ET ADDRESS, CITY, STATE, ZIP CODE 1 E FLAMING RD LATHE, KS 66061		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	walked all over the urresidents. He/she sa listened when I read to said the resident did it music or to the TV. Hon and muted with the music for visual and a An interview on 6/5/1 nursing staff J said the doll baby, occasionally activities with a certain clapped along with the An interview on 6/5/1 nursing staff J said or were responsible for residents. He/she said daily on the unit dependent was an activity calendar. We resident was an activity calendar. We resident was an activity residents' daily activity residents' daily activity residents' daily activity residents activity residents activity residents activity residents activity residents on the secondactivity program and said he/she completed portion of the MDS by a progress note regard did the care plan for enderstands.	esident loved the doll, and hit, talked to staff and other id at times the resident to the residents. He/she not pay much attention to de/she said they have the TV expendence of the compact disc (CD) playing auditory stimulation. 3 at 2:05 P.M. with licensed expendence resident liked to carry and y enjoyed doing 1 on 1 in board game, and at times expendence doing activities with the id what activities with the id what activities they did inded on what was on the expendence of the passive participant on pation record. He/she said did when the facility first in the literature of the activity assessment or care plan for planning the idea of the activity assessment or the fifth day and then made ading the resident. He/she said deach resident. He/she said deach resident. He/she said	F	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		17E641	B. WING _			C 06/12/2013
	OVIDER OR SUPPLIER	EHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO. 201 E FLAMING RD OLATHE, KS 66061	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279	secured unit did all tresiding on the unit. expected the staff or refer to the care plan program from the care. An interview on 6/5/administrative nursing should have an indivactivities. He/she and only the monthly act an initialized activity. The facility provided revision date of 9/1/plan of care will be eand updated in accoregulatory requirements. The proceduladditional problem and MDS, which will need Plan. All direct care	d the staff who work on the he activities for the residents He/she said he/she anyone doing activities to and gauge the activity are plan.	F2	279		
F 314 SS=G	activity care plan for residentongoing indi accordance to his/he 483.25(c) TREATME PREVENT/HEAL PREVENT/HEAL PREVENT/HEAL PREVENT, the facility who enters the facility does not develop president.	ENT/SVCS TO	F	314		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		NSTRUCTION		PLETED
		17E641	B. WING				C 12/2013
	OVIDER OR SUPPLIER	EHABILITATION CENTER		201 E	ADDRESS, CITY, STATE, ZIP CODE FLAMING RD THE, KS 66061		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 314	pressure sores receservices to promote prevent new sores for the sample included observation, intervietacility failed to previstage II pressure ulcer for 1 reviewed for pressure ulcer for 14 which indicated intact. The resident assistance of 1 staff toileting and personate to the sample of the sam	ble; and a resident having lives necessary treatment and healing, prevent infection and rom developing. T is not met as evidenced d a census of 49 residents. Based on w, and record review the lent the development of 1 ler and 1 unstageable (#4002) of 3 residents re ulcers. admission Minimum Data Set (*7-13 documented the view for Mental Status score d the resident was cognitively required extensive with bed mobility, transfers, all hygiene. The resident did licers. Bea Assessment (CAA) for ving (ADLs) documented the ambulate with a rolling 2-20-13, but was chair bound	F	314			
	resident required ex	ence CAA documented the tensive assistance with nence, and a recent urinary					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E641	B. WING				C / 12/2013	
NAME OF PROVIDER OR SUPPLIER ROYAL TERRACE NURSING & REHABILITATION CENTER			1	201	T ADDRESS, CITY, STATE, ZIP CODE E FLAMING RD ATHE, KS 66061			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 314	resident with a Brade determine a resident pressure ulcers) of 17 resident was at risk for ulcers, and preventive protect the resident's. The 3-7-13 dietician resident received a resident was 1.5 - 5.7 g protein was low at 4.8 was 6.4 - 8.9 g/dl. The the resident received daily, protein supplentimes daily, encourage intake and increased. The 2-28-13 Admission to reposition the resident received assistance of 1 staff of toileting, had pneumous lungs) and received at risk nutritionally reland interventions includiet compliance, honor requests for food, encourage intaked to sleep late, so the resident preferred due to history of a gaprocedure involving the intestine for the purposition for the purpos	Ulcer CAA documented the n Score (an assessment to 's risk for development of which indicated the or development of pressure emeasures were in place to skin. Indee documented the egular diet, had good intake albumin (a test to to for protein in the blood) was deciliter (g/dl). The normal range me dietician recommended protein snacks two times ment 30 milliliters (ml) three ment of increased fluid protein. On Care Plan directed staff dent every 2 hours, required with bed mobility, 2 staff with onia (inflammation of the an intravenous (IV) antibiotic. In identified the resident was ated to a low Albumin level uded; monitoring intake and or food preferences, honor courage fluids, the resident offer snacks upon arising, it small meals plus snacks	F	314				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
17E641			B. WING		С			
NAME OF PROVIDER OR SUPPLIER ROYAL TERRACE NURSING & REHABILITATION CENTER			B. WING	201	ET ADDRESS, CITY, STATE, ZIP CODE E FLAMING RD ATHE, KS 66061	06/	12/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORPREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE ADEFICIENCY)		SHOULD BE COMPLE		
F 314	supplements as order daily as ordered and daily dai	red, protein supplement dietician visits as needed. specific dates the plemented. In documented the resident auther skin breakdown due to weakness, and bladder and declined ement to reposition. The evate his/her lower interventions included a author area fluids often promote hydration, assession status, weekly skin aily cares and report and es in skin color and turgor to rage the resident to turn and in bed and while sitting in mote circulation and an also documented the are reducing cushion in the pressure and promote specific dates the plemented. 3-19-13 nurse's note at 1:45 resident with an open area buttock that measured 0.5 aumference. The facility Calazime cream (a skin	F	314				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CON	(X3) DATE SURVEY COMPLETED		
		17E641	B. WING			1	C / 12/2013
NAME OF PROVIDER OR SUPPLIER ROYAL TERRACE NURSING & REHABILITATION CENTER				201 E	ADDRESS, CITY, STATE, ZIP CODE FLAMING RD HE, KS 66061	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 314	Record review of the 11:45 A.M. documer of heel pain and stat dark colored blister Staff notified the phyfor skin prep (a skin friction) to the blister daily, place a pillow while in bed, and plaspecialized boot that heels) boot at all time. The 3-22-13 care play with a right heel ulcan heel. Interventions ordered, a low air locirculation and complete at his/her lower pressure relieving dordered to decrease by the wound clinical Record review of the A.M. documented the additional lab due to confusion. Record review of the time written documented the resident had swinght heel blister was requested a Dopple arterial blood flow in	d a wheel chair cushion. e 3-22-13 nurse's note times need the resident complained ff noted a 4 cm by (x) 2.5 cm on the resident 's right heel. ysician and received an order protectant that reduced on the right heel two times under the resident 's calves ace the right foot in a Prafo (a treduced pressure on the nees. an documented the resident er and redness on the left included treatment as ss mattress to promote fort, encourage the resident to er extremities, provide evices on both heels as a pressure and seen weekly for treatment and review. e 3-25-13 nurse's note 6:30 ne physician ordered on the resident's increased e 3-25-13 nurse's note with no ented on 3-22-13 at 3:30 P.M. elling of the lower legs. The spurple in color and restudy (a test to determine in the lower extremities).	F	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	17E641		B. WING	B. WING			C 12/2013		
NAME OF PROVIDER OR SUPPLIER ROYAL TERRACE NURSING & REHABILITATION CENTER			l	20	EET ADDRESS, CITY, STATE, ZIP CODE D1 E FLAMING RD DLATHE, KS 66061	, 30.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH FOR THE APPLICATION OF THE APPLICATION O		LD BE COMPL			
F 314	compressibility from the femoral veins (blood withigh or bone or femuly popliteal veins (blood knee) in the calves and documented no evide thrombosis (blood cloextremities. Record review of the documented clarificate therapy 2-3 times were therapy assessment of the resident's bed to it participation with transion on 4-2-13 the resident therapy. Nurse's notes dated 4 documented the resident (a slight indemexcess fluid accummented excess fluid accummented the area opened and staff noting received an order for dressing used for treatdressing. The 4-24-13 nurse's redocumented the resident of the wound clinic.	the bilateral common vessels located near the r) through the bilateral vessels located behind the ad the impression ince of deep venous t) in the bilateral lower 3-29-13 nurse's note ion for an order for Physical ekly for 4 weeks, and a for use of mobility rails on increase the resident's sers. In completed IV antibiotic 4-16-13 at 11:30 A.M. Itent with 2 plus pitting tation of the tissue due to collation) in both lower in the project of the project in the content of the tissue due to collation in both lower in the project in the content of the tissue due to collation of the tissue due to collation in both lower in the project in the content of the tissue due to collation in the tissue due to collation in both lower in the project in the proje	F	314					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		17E641	B. WING			1	C 12/2013
NAME OF PROVIDER OR SUPPLIER ROYAL TERRACE NURSING & REHABILITATION CENTER			l	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E FLAMING RD OLATHE, KS 66061			12/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		HOULD BE COMPLET	
F 314	resident had black es right heel. The physical documented the residual four extremities an insufficiency (abnorm with edema of the low physician documented pressure ulcer on the The X-ray report of the 4/25/13 documented and the radiologist disosteomyelitis (infection Record review on 5-9 the resident started of medication to expel filmilligrams (mg) daily Nurse's note dated 5-documented the residuent at 8:43 Physical Components of the comp	char (dead tissue) on the cian debrided the wound and dent with positive pulses in d displayed venous al blood flow through veins) wer extremities. The d his/her findings as a right heel. The resident's right foot dated the resident with swelling d not observe a fracture or on of the bone). The distriction of the body of the resident with swelling d not observe a fracture or on of the bone). The distriction of the body of the body of the body of the body. The distriction of the body of the distriction of the body of the body. The distriction of the body of the distriction of the body of the distriction of the body of the body. The distriction of the body of the distriction of the body of	F	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		17E641	B. WING				C / 12/2013
NAME OF PROVIDER OR SUPPLIER ROYAL TERRACE NURSING & REHABILITATION CENTER			I	201	ET ADDRESS, CITY, STATE, ZIP CODE E FLAMING RD ATHE, KS 66061	1 00	12/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AI DEFICIENCY)		HOULD BE COMPLET	
F 314	Observation on 6-5-1 ambulance at the resident to the horest the resident to the horest the resident stated he/sh and it covered the "v said he/she wore spet them on all the time. was not able to reposindependently and no resident said his/her. During staff interview administrative staff D and the physician set hospital. During staff interview direct care staff O state "scoot" his/her hips a was not able to stay of support pillow to hold care staff stated they the bed and he/she of He/she stated someti upset and refused cate and came back 5 mir cooperative. Direct care repositioned the resident did refuse years of the resident developed left buttock on March repositioned the resident with the resident w	3 at 8:32 A.M. revealed the ident's room door to transfer spital. In 6-5-13 at 7:27 A.M. the e had a sore on his/her heel whole" heel. The resident scial boots and had to keep. The resident stated he/she sition him/herself in bed seded the help of staff. The legs hurt most of the time. In 6-5-13 at 9:47 A.M. stated the resident had pain in the resident to the In 6-5-13 at 1:49 P.M. stated the resident was able to and turn from side to side but on his/her side without a him/her in position. Direct kept the resident's heels off id not refuse to do it. It is the resident was are staff O stated he/she dent every hour and the esterday because of leg pain. M. licensed nurse H stated an open area on his/her	F	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	17E641		B. WING	B. WING			C 06/12/2013	
NAME OF PROVIDER OR SUPPLIER ROYAL TERRACE NURSING & REHABILITATION CENTER			•	20	EET ADDRESS, CITY, STATE, ZIP CODE 01 E FLAMING RD 0LATHE, KS 66061			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 314	such as not remembrif he/she received me H stated the resident bed on his/her own a staff for positioning at He/she stated the prohealed on 4-5-13. Lithe resident had a bliwore a Prafo boot afficensed staff I stated the pressure ulcers, resident every 2 hour of bowel and bladder needs. After the devulcers, the resident mis/her heels, had Prothe calves and requir positioning in bed. On 6-5-13 at 2:55 Puthe resident was reposition his/her sells the resident was reposited his/her needs, are position his/her sells. The facility provided and Procedure document facility without prodevelop pressure sold clinical condition den unavoidable. The facility failed to pan avoidable stage II unstageable pressure.	sident had confusion at times ering staff was in the room or edications. Licensed nurse was not able to get out of and required assistance of and liked to stay in bed. essure ulcer on the buttocks censed nurse H also stated ister on his/her right heel and ter they found the wound. If on 6-5-13 at 2:42 P.M. If that prior to development of staff repositioned the rs, the resident was continent r, and able to state his/her relopment of the pressure now received skin prep for afo boots or a pillow under red assistance of staff for M. direct care staff P stated ositioned every hour, able to and was not able to f without assistance of staff. 9-1-11 Pressure Ulcer Policy mented if a resident entered essure sores, he/she did not res unless the resident's	F	314				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
	17E641		B. WING			С	
NAME OF PR	OVIDER OR SUPPLIER	172041	D. Wiite		REET ADDRESS, CITY, STATE, ZIP CODE	06/	12/2013
		EHABILITATION CENTER		20	01 E FLAMING RD DLATHE, KS 66061		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE